STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
155.0			A. BUILDING:			
1L6016281		B. WING		C 04/04/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MEADOV	VBROOK MANOR - L	AGRANGE 339 9TH A	WENUE GE, IL 6052:			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	(D	PROVIDER'S PLAN OF CORRECT	ON (X5)	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S 000	Initial Comments		S 000			
	Facility Report Inve	stigation IL110784			1	
S9999	Final Observations		S9999		I	
	Licensure Violation: 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a)	S				
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory coof nursing and othe policies shall comp	Il have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ing of at least the idvisory physician or the immittee, and representatives in services in the facility. The ly with the Act and this Part. Is shall be followed in operating				
	Section 300.1210 Nursing and Person	General Requirements for nal Care				
Ø	and services to atta practicable physica well-being of the re each resident's con plan. Adequate and	Il provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each		Attachment of Licensu		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 04/22/19

STATE FORM

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016281 04/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 339 9TH AVENUE **MEADOWBROOK MANOR - LAGRANGE** LA GRANGE, IL 60525 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, a) employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to transfer residents with a mechanical lift according to their policy and in a safe manner. This failure resulted in R4 sustaining a fractured hip and lacerations to the face and head following a fall from a mechanical lift.

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This applies to 5 of 5 residents (R4, 5, 6, 7 and R8) reviewed for mechanical lift transfers, in the

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		IL6016281	B. WING		C 04/04/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MEADO	WBROOK MANOR - L	AGRANGE 339 9TH A				
		LA GRAN	GE, IL 60525			
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S9999	Continued From pa	ge 2	S9999		11	
	sample of 8.				11	
	The Sedimon include					
	The findings include	8:			П	
	Department they have resident fall from a the resident sustain	the facility reported to the ad begun an investigation of a mechanical lift that resulted in hing a right hip fracture and ace and back of head.			П	
	showing the 5th floo	e facility provided a list or housing 64 residents nts requiring a 2 person ansfer.				
	giver) stated, prior of the mechanical lift of the hall while V9, C was working in the stated V9 saw her of stated she was transmechanical lift from wheelchair. She rathe foot of the bed, move the wheelchait turned back, R4 was the top of his head. know what happenedoes not understandetached from the has been performing mechanical lift for Fhim in the facility in the facility had ever that staff would assist she had never met this incident. V4 wimmediately bent desired in the staff would assist the s	4:24pm, V4 (private care to V4's fall, she had retrieved from outside the room across NA (Certified Nurse Assistant) room across the hall. V4 take the mechanical lift. V4 taferring R4 with the in the bed to the motorized itsed R4 over the space past then turned away from R4 to the intrinction and when she as on the floor, bleeding from V4 stated, she just does not ed, did not hear R4 fall and and how the lift sling came to be lift. Additionally, V4 stated she ag transfers with the R4 since she began caring for 2008. V4 stated no staff in the objected and it was not often the Director of Nurses before each on to explain, she own to R4 on the floor to tend owel to his head and at that				

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		IL6016281	B. WING		04/0	; 4/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	·	
MEADO\	WBROOK MANOR - L	AGRANGE 339 9TH A	WENUE GE, IL 6052!	ō		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	Continued From pa	ge 3	\$9999			
	time, V9 entered th not yet called anyon believed V9 came to for another resident On April 2, 2019 at "the first one in the and V4 was kneeling	e room. V4 stated she had ne to help. V4 stated she to get the mechanical lift to use				
	never known V4 to transfers. V9 state R4 in the facility sin working in the facilithe fall (March 19, across the hall from another resident an mechanical lift from working in. V9 stat retrieve the mechan at which time he sa "it is not for me to s	2:18pm, V9 stated he had ask for assistance with d V4 had been working with ace long before he started ty. V9 stated, on the day of 2019), he was in the room in R4's room working with ad did see V4 retrieve the in outside the room he was ed, he went to R4's room to nical lift and assist if needed, aw R4 on the floor. V9 stated, ay" if any CNA's in the facility al lifts by themselves without				
	a typed message o has been transferring R4 stated he doesn they sometimes tak stated that one staff	12:16pm, R4 stated (through n a communication device) V4 ng him for years by herself. It like waiting for the staff as a long time to arrive. R4 if sometimes transfers him. It like the lets up.				
	the facility June 200 (minimum data set)	eet shows R4 was admitted to 05. R4's most recent MDS dated April 1, 2019 shows a w for mental status) score of				*

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transfers.

On April 3, 2019 at 11:55am, R7 was in bed. turned to her right side. R7 stated all transfers are done by staff using the mechanical lift and staff assists with positioning. R7 stated "usually"

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		IL6016281	B. WING		I .	C 04/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S1	TATE, ZIP CODE		
MEADON	WBROOK MANOR - L	AGRANGE 339 9TH	AVENUE			
	TOTAL TOTAL	LA GRAM	NGE, IL 60525			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 5	S9999			
	one is there. R7 stare "good at it" and transfers, but will no	transfer, but occasionally just ated she knows which CNA's "let's them" perform the ot allow newer or unfamiliar asfers by themselves.				
	the facility Novemb MDS dated March of 15 (memory and MDS shows R7 is t	eet shows R7 was admitted to er 2009. R7's most recent 18, 2019 show a BIMS score cognition fully intact). Also, otally dependent for and to provide extensive ansfers.				
	hallway propelling a she is always trans and it is usually dor sometimes she is to	12:50pm, R8 was in the facility a motor wheelchair. R8 stated ferred with a mechanical lift ne by 2 staff. R8 stated, ransferred by only one staff. was transferred by one staff				
	the facility October dated March 18, 20 (memory and cognimpaired). Also, M	eet shows R8 was admitted to 2017. R8's most recent MDS 019 show a BIMS score of 9 ition mildly to moderately DS shows R8 is totally requires 2 persons to provide ce for all transfers.				
	Nurses) stated she surprised that V4 w transfers by themso was done following strict requirement to	10:30am, V2 (Director of had not met V4 and was rould be doing mechanical lift elves. V2 stated, an in-service the incident, re-enforcing the hat 2 staff must always be mechanical lift transfer.				
		3:49am, V3 (Medical Doctor) on working with R4 for many				

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SSS= Sit to Stand with Standard Sling with 2

SSC= Sit to Stand with Carrier Sling with 2

H= Total Lift Transfer ("HoyerTM type") with 2

caregivers (Extensive Assist 2 people)

caregivers (Extensive Assist 2

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